Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Global Molecular Labs

Respondent Name
TASB Risk Mgmt Fund

MFDR Tracking Number
M4-17-2964-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 8, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The charges referenced herein were filed with the Carrier and denied for 'pre-certification or authorization or notification absent". We have requested reconsideration from the carrier and they are maintaining the rationale."

Amount in Dispute: $7,855.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Fund denied the charges for code G0483 and 80307 due to the lack of supporting documentation to support the charges being billed."

Response Submitted by: TASB

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2017	80307, G0483	$7,855.00	$`393.76

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the requirements for filing a medical fee dispute.
2. 28 Texas Administrative Code §133.210 sets out the documents required to be filed with medical bills during the medical billing process.
3. 28 Texas Administrative Code Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage.

4. 28 Texas Administrative Code §134.203 sets out the reimbursement for clinical laboratory services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150 – Payment adjusted because the payer deems the information submitted does not support the this level of service
   - 193 –Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. Did the requestor meet division documentation requirements?
2. Did the carrier appropriately raise reasonableness and medical necessity?
3. Is reimbursement due?

Findings

1. The carrier denied payment with claim adjustment code 150 – "Payment adjusted because the payer deems the information submitted does not support this level of service."

   Similarly, in its response to this medical fee dispute, the carrier cites the lack of supporting information and/or documentation as a reason for denial of payment. The process for a carrier's request of documentation not otherwise required by 28 TAC 133.210 is detailed in section (d) of that section as follows:

   "Any request by the insurance carrier for additional documentation to process a medical bill shall:
   (1) be in writing;
   (2) be specific to the bill or the bill's related episode of care;
   (3) describe with specificity the clinical and other information to be included in the response;
   (4) be relevant and necessary for the resolution of the bill;
   (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
   (6) indicate the specific reason for which the insurance carrier is requesting the information; and
   (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation."

   No documentation was found to support that the carrier made an appropriate request for additional documentation during the billing process with the specificity required by rule. The division concludes that carrier failed to meet the requirements of 28 TAC 133.210(d).
2. The insurance carrier in its response makes assertions that question the appropriateness and medical necessity of the services in dispute. Although these assertions are made based on language taken from the ODG, the issues raised indicate that the insurance carrier is denying payment based on medical necessity.

   For example, the insurance carrier asserts "…the testing is not fully supported at this early stage unless there is documentation of prior use of opiods pre date of injury as per ODG."

   Review of the 2017 ODG Treatment, Integrated Treatment/Disability Duration Guidelines, Pain (Chronic) finds;

   Recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances.

   Indications for UDT:

   At the onset of treatment: (1) UDT is recommended at the onset of treatment of a new patient who is already receiving a controlled substance or when chronic opioid management is considered.

Health care provided in accordance with the ODG is presumed reasonable as specified in (c) of Rule §137.100. Section (e) of that same rule allows for the insurance carrier to retrospectively review reasonableness and medical necessity:

> "**An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017**."

28 Texas Administrative Code Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage. Applicable 28 TAC §19.2003 (b)(31) defines retrospective review as "A form of utilization review for health care services that have been provided to an injured employee."

No documentation was found to support that the insurance carrier retrospectively reviewed the reasonableness and medical necessity of the service in dispute pursuant to the minimal requirements of Chapter 19, subchapter U as required. The insurance carrier failed to follow the appropriate administrative process and remedy in order to address its assertions regarding appropriateness of care and medical necessity.

3. The services in dispute are clinical laboratory and are addressed in the CMS Clinical Laboratory Fee Schedule. 28 Texas Administrative Code §134.203(e) states:

> The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:
>
> (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and
>
> (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

CMS payment policy files identify those clinical laboratory codes which contain a professional component, and those which are considered technical only. The codes in dispute are not identified by CMS as having a possible professional component, for that reason, the MAR is determined solely pursuant to 28 Texas Administrative Code §134.203(e)(1).

The maximum allowable reimbursement(MAR) for the services in dispute is 125% of the fee listed for the codes in the 2017 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at http://www.cms.gov. The total MAR is calculated as follows:

Date of Service	Submitted Code	Medicare Allowable	Maximum Allowable Reimbursement
January 30, 2017	80307	$61.02	$61.02 x 125% = $76.38
January 30, 2017	G0483	$253.87	$253.87 x 125% = $317.38
		Total	$393.76

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $393.76.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $393.76 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		July 7, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.